



Application for Admission

ADULT DAY HEALTH

Name _____ Date _____

Address _____

Phone _____

Soc. Security # _____ Date of Birth _____ Marital Status _____

Educational Level _____ Religious Preference _____

How many days a week would applicant attend Day Health Center? _____

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

Anticipated Date of Admission _____

Does applicant live alone? ___ Yes ___ No

If no, what is the situation? _____

Responsible Party _____ Relationship _____

Address _____

Phone _____ Alternate Phone _____

Applicant's Personal Physician _____

Address _____

Phone _____ Fax _____

Applicant's Hospital Preference _____

Diagnosis _____

Allergies _____ Code Status _____

Payment Source: Private Pay BayPath Long Term Care Insurance
 Medicaid # _____

If Medicaid, has applicant been screened for ADHC services by ASAP nurse? _____

If Private Pay, who will receive the bill? Name _____

Address _____

Phone _____

Other Insurance or HMO? Please list name and numbers:

OTHER FAMILY MEMBERS

Name _____ Phone _____

Address _____

Relationship _____

Name _____ Phone _____

Address _____

Relationship _____

WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY?

Name _____ Relationship _____

Address _____

Phone _____ Alternate Phone _____

Other agencies involved _____

Type of services received _____

Is the applicant able to manage their personal & financial affairs? ___ Yes ___ No

If no, who assumes responsibility?

Name _____ Phone _____

Address _____

Relationship _____

APPLICANT OR RESPONSIBLE PARTY

Signature _____ Date _____

Please Print Name _____